CONTRACT #9
RFS # 350.40-044
FA # 07-20304-00

Department of Finance & Administration
Benefits Administration

VENDOR:
BlueCross BlueShield of Tennessee

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
BENEFITS ADMINISTRATION
312 Eighth Avenue North
Suite 2600 William R. Snodgrass Tennessee Tower
Nashville, Tennessee 37243
Phone (615) 741-3590 or (800) 253-9981
FAX (615) 253-8556

Dave Goetz
COMMISSIONER

Laurie Lee
EXECUTIVE DIRECTOR

MEMORANDUM

To: James White, Executive Director, Fiscal Review Committee

From: Brian Haile, Deputy Director, Benefits Administration BH

Date: May 29, 2008

RE: Amendment for AccessTN contract adds invoicing responsibilities

Please find attached a Non-Competitive Amendment request to add language to the existing contract with BlueCross BlueShield of Tennessee (BCBST) signed by Commissioner Goetz. The modification to the AccessTN contract through this amendment provides for the addition of responsibilities to develop, implement and maintain the systems and reports necessary to invoice the State directly for a portion of the premium payment. The amendment transfers this responsibility from a third party to BCBST with both parties favoring this approach. The amendment is slated to take effect August 1, 2008.

The base contract and all prior amendments are included for review as is a draft of the amendment to address the inclusion of responsibilities associated with programming fees and invoicing for premium payments for individuals eligible for the AccessTN program.

Thank you for your consideration of this request.

REQUEST: NON-COMPETITIVE AMENDMENT

APPROVED
Commissioner of Finance & Administration **Date:**

EACH REQUEST ITEM BELOW MUST BE DETAILED OR ADDRESSED AS REQUIRED.	
1) RFS #	#350.40-044-07
2) State Agency Name :	Finance and Administration
EXISTING CONTRACT INFORMATON	
3) Service Caption :	To provide statewide administrative services for the AccessTN program.
4) Contractor :	BlueCross BlueShield of Tennessee
5) Contract #	FA-07-20304-00
6) Contract Start Date :	February 13, 2007
7) Current Contract End Date IF all Options to Extend the Contract are Exercised :	December 31, 2011
8) Current Total Maximum Cost IF all Options to Extend the Contract are Exercised :	$5,750,000.00
PROPOSED AMENDMENT INFORMATON	
9) Proposed Amendment #	# 3
10) Proposed Amendment Effective Date : (attached explanation required if date is < 60 days after F&A receipt)	August 1, 2008
11) Proposed Contract End Date IF all Options to Extend the Contract are Exercised :	December 31, 2011
12) Proposed Total Maximum Cost IF all Options to Extend the Contract are Exercised :	$5,750,000.00

13) Approval Criteria : (select one)		
	☒	**use of Non-Competitive Negotiation is in the best interest of the state**
	☐	**only one uniquely qualified service provider able to provide the service**

14) Description of the Proposed Amendment Effects & Any Additional Service :

The amendment expands the Contractor's scope of services to include the development and associated programming necessary to invoice the State directly for the AccessTN premiums and other related program changes. The State shall approve estimates for such work in writing in advance.

15) Explanation of Need for the Proposed Amendment :

Currently another entity determines the eligibility of an individual for premium assistance and the level of the assistance. This

amendment would allow the Contractor to invoice the State directly, streamline the process, minimize the potential for errors and result in a more efficient work process.

16) Name & Address of Contractor's Current Principal Owner(s) :
(not required if proposed contractor is a state education institution)

BlueCross BlueShield of Tennessee, Inc., 801 Pine St - 4G, Chattanooga, TN 37402

17) Documentation of Office for Information Resources Endorsement :
(required only if the subject service involves information technology)

select one:	☒ Documentation Not Applicable to this Request	☐ Documentation Attached to this Request

18) Documentation of Department of Personnel Endorsement :
(required only if the subject service involves training for state employees)

select one:	☒ Documentation Not Applicable to this Request	☐ Documentation Attached to this Request

19) Documentation of State Architect Endorsement :
(required only if the subject service involves construction or real property related services)

select one:	☒ Documentation Not Applicable to this Request	☐ Documentation Attached to this Request

20) Description of Procuring Agency Efforts to Identify Reasonable, Competitive, Procurement Alternatives :

BlueCross BlueShield of Tennessee is in an excellent position to deal with the proposed requirement and is willing to take on the additional responsibility. The agency did not attempt to identify competitive procurement alternatives.

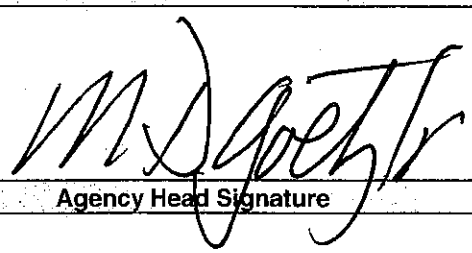
21) Justification for the Proposed Non-Competitive Amendment :

Under the current arrangement, a third party, Patient Services Incorporated (PSI), determines eligibility of applicants for premium assistance subsidies from the State. Presuming that the applicant will enroll and remit the remainder amount of his or her first month premium, PSI pays the carrier, BCBST, the portion of the State's share (i.e., the premium subsidy amount). If the applicant decides not to enroll, then BCBST must return the state subsidy amount to PSI. The reconciliation process therefore requires a substantial amount of effort and increases the risk of error. Yet, the existing arrangement, while imperfect, allowed the State to implement the program much more quickly and served the State reasonably well during the first phase of the program (while enrollment was relatively smaller).

The State is now in a position to move to a more streamlined process, which will reduce the administrative burden and the risk of mistakes. Under the new system, PSI will determine eligibility of applicants for premium assistance subsidies from the State. BCBST will then invoice the member for his or her remainder amount of the premium. At the time that the member remits payment, BCBST will draft the State's account for the premium subsidy and immediately enroll the person into the program. Both PSI and BCBST favor this new approach.

This new system offers several advantages to the State. First, the new process will eliminate the need to advance a third vendor the funds for premium assistance subsidies. Second, it will substantially reduce the burden of reconciling payments – which is particularly important now that enrollment in the program is accelerating. In terms of cost, BCBST has agreed to assume the new reporting function associated with the new approach for a nominal fee. For these reasons, we believe that this amendment is in the best interests of the State.

REQUESTING AGENCY HEAD SIGNATURE & DATE :
(must be signed & dated by the ACTUAL procuring agency head as detailed on the Signature Certification on file with OCR— signature by an authorized signatory will be accepted only in documented exigent circumstances)



Agency Head Signature

5/29/08

Date

CONTRACT SUMMARY SHEET

021908

RFS #	Contract #
350.40-044-07	FA-07-20304-
State Agency	**State Agency Division**
Dept. of Finance and Administration	Benefits Administration
Contractor Name	**Contractor ID # (FEIN or SSN)**
Blue Cross Blue Shield of Tennessee, Inc.	☐ C- or ☒ V- 62-0427913

Service Description

To provide statewide administrative services for the AccessTN program. **Amendment adds programming & invoicing.**

Contract Begin Date	Contract End Date	SUBRECIPIENT or VENDOR?	CFDA #
February 13, 2007	December 31, 2009	Vendor	

Mark Each TRUE Statement

☒ Contractor is on STARS

☒ Contractor's Form W-9 is on file in Accounts

Allotment Code	Cost Center	Object Code	Fund	Funding Grant Code	Funding Subgrant Code
317.86	21	891	54		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007			$829,000		$829,000
2008			$1,835,000		$1,835,000
2009			$1,835,000		$1,835,000
2010			$1,251,000		$1,026,000
TOTAL:			$5,750,000		$5,750,000

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
FY: 2007	$829,000	
FY: 2008	$1,835,000	
FY: 2009	$1,835,000	
FY: 2010	$1,251,000	
TOTAL:	$5,750,000	
End Date:	Dec. 31, 2009	Dec. 31, 2009

State Agency Fiscal Contact & Telephone #

John G. Anderson
13th Floor, Tennessee Tower
615-741-8642

State Agency Budget Officer Approval

Funding Certification (certification, required by T.C.A., § 9-4-5113, that there is a balance in the appropriation from which the obligated expenditure is required to be paid that is not otherwise encumbered to pay obligations previously incurred)

Contractor Ownership (complete for ALL base contracts— N/A to amendments or delegated authorities)

☐ African American ☐ Person w/ Disability ☐ Hispanic ☐ Small Business ☐ Government
☐ Asian ☐ Female ☐ Native American ☐ NOT Minority/Disadvantaged ☐ Other

Contractor Selection Method (complete for ALL base contracts— N/A to amendments or delegated authorities)

☐ RFP ☐ Competitive Negotiation * ☐ Alternative Competitive Method *
☐ Non-Competitive Negotiation * ☐ Negotiation w/ Government (ID, GG, GU) ☐ Other *

*** Procurement Process Summary** (complete for selection by Non-Competitive Negotiation, Competitive Negotiation, OR Alternative Method)

AMENDMENT THREE
TO FA-07-20304-00

This Contract Amendment is made and entered by and between the Access Tennessee Board of Directors, hereinafter referred to as the "State" and BlueCross BlueShield of Tennessee, Inc., hereinafter referred to as the "Contractor". It is mutually understood and agreed by and between said, undersigned contracting parties that the subject Contract is hereby amended as follows:

1. The text of Contract Section C.3. is deleted in its entirety and replaced with the following:

C.3. Payment Methodology. The Contractor shall be compensated based on the payment rates herein for service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in Section C.1.

a. The Contractor's compensation shall be contingent upon the satisfactory completion of units, milestones or increments of service defined in Section A.

b. The Contractor shall be compensated for said units, milestones, or increments of service based upon the following payment rates:

PMPM Administrative Fee	PMPM 2007	PMPM 2008	PMPM 2009
AccessTN Plans (PPO)	$18.57	$18.57	$18.57
AccessTN Plan 2500 (HSA eligible HDHP)	$26.00	$26.00	$26.00

If the State, subject to a sixty (60) day notice, elects to provide for the administration of the Pharmacy Benefit (as detailed in A.10) or Disease Management (as detailed in A.9.7) or to collect premiums (as detailed in A.3) then the PMPM administrative fee shall be reduced by the associated amount detailed in the schedule below. If the adjustment takes place in the first or second year of the contract extension provided for in B.2., then the carve out reduction amounts will be increased by the same percentage that resulted from the process outlined below in C.3.1 or C.3.2.

Potential Carve Out	PMPM 2007	PMPM 2008	PMPM 2009
Reduction for Disease Management	$1.09	$1.09	$1.09
Reduction for Pharmacy	$0.78	$0.78	$0.78
Reduction for Premium Collection	$1.24	$1.24	$1.24

The Contractor shall be compensated for the application assistance service provided at a monthly rate of $4,687.50 per staff member and includes all costs associated in the provision of the service per staff member. The Contractor may be required by the State to provide up to four (4) individual staff assigned to this function on a monthly basis for the term of the Contract, but the number of staff required may be reduced by the State following discussion with the Contractor at any time should the need for the service no longer exist. The State will make a one-time payment of Five Thousand Dollars ($5,000.00) for the Contractor's expense to identify applications that had previously not qualified under the presumptive eligibility category and sending these applications for underwriting services.

The Contractor shall be compensated for the development and associated programming necessary to invoice the State directly for the AccessTN premium assistance funds (as detailed in A.3.7) and other, related program changes. The programming costs incurred by the Contractor shall be compensated at an hourly rate of seventy dollars ($70.00), and the total cost for such programming shall not exceed thirty thousand dollars ($30,000.00). The State shall approve estimates for such work in writing in advance of any work performed.

The Contractor shall submit monthly invoices, in form and substance acceptable to the State with all of the necessary supporting documentation, prior to any payment. Such invoices shall be submitted for completed units of service for the amount stipulated. The State shall compensate the Contractor monthly for all services outlined in this contract, at the PMPM and other service based rates indicated, based upon the number of members certified by the Contractor to the State.

2. The following provision is added as Contract Section A.3.7.:

A.3.7. The Contractor shall assume the responsibility for directly invoicing the State for the premium assistance funds as of August 1, 2008 for the duration of the contract or as otherwise specified by the State. This invoicing shall occur on a monthly basis and shall accommodate the AccessTN billing cycle.

The revisions set forth herein shall be effective August 1, 2008. All other terms and conditions not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF:

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

CONTRACTOR SIGNATURE **DATE**

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

ACCESS TENNESSEE BOARD OF DIRECTORS:

M. D. GOETZ, JR., CHAIRMAN **DATE**

APPROVED:

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M. D. GOETZ, JR., COMMISSIONER **DATE**
DEPARTMENT OF FINANCE AND ADMINISTRATION

JOHN G. MORGAN, COMPTROLLER OF THE TREASURY **DATE**

CONTRACT SUMMARY SHEET

8-8-05

RFS #	Contract #
350.40-044-07	FA-07-20304-02
State Agency	**State Agency Division**
Dept. of Finance and Administration	Division of Insurance Administration
Contractor Name	**Contractor ID # (FEIN or SSN)**
Blue Cross Blue Shield of Tennessee, Inc.	☐ C- or ☒ V- 62-0427913

Service Description

To provide statewide administrative services for the AccessTN program.

Contract Begin Date	Contract End Date	SUBRECIPIENT or VENDOR?	CFDA #
February 13, 2007	December 31, 2009	Vendor	

Mark, if Statement is TRUE

☒ Contractor is on STARS as required ☒ Contractor's Form W-9 is on file in Accounts as required

Allotment Code	Cost Center	Object Code	Fund	Funding Grant Code	Funding Subgrant Code
317.86	21	891	54		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007			$829,000		$829,000
2008			$1,835,000		$1,835,000
2009			$1,835,000		$1,835,000
2010			$1,251,000		$1,026,000
TOTAL:			$5,750,000		$5,750,000

OCR RELEASED JUN 2 5 2007 TO ACCOUNTS

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
FY: 2007	$604,000	$225,000
FY: 2008	$1,610,000	$225,000
FY: 2009	$1,610,000	$225,000
FY: 2010	$801,000	$450,000
TOTAL:	$4,625,000.00	$1,125,000.00
End Date:	Dec. 31, 2009	Dec. 31, 2009

State Agency Fiscal Contact & Telephone #

John G. Anderson JM
13th Floor, Tennessee Tower
615-741-8642

State Agency Budget Officer Approval

Funding Certification (certification, required by T.C.A., § 9-4-5113, that there is a balance in the appropriation from which the obligated expenditure is required to be paid that is not otherwise encumbered to pay obligations previously incurred)

Contractor Ownership

☐ African American ☐ Disabled ☐ Hispanic ☐ Small Business ☒ NOT minority/disadvantaged
☐ Asian ☐ Female ☐ Native American ☐ OTHER minority/disadvantaged—

Contractor Selection Method

☒ RFP ☐ Competitive Negotiation ☐ Alternative Competitive Method
☐ Non-Competitive Negotiation ☐ Government ☐ Other

Procurement Process Summary

JUN 27

AMENDMENT TWO
TO CONTRACT NUMBER FA-07-20304-00

The Contract, by and between the Access Tennessee Board of Directors, hereinafter referred to as the State and BlueCross BlueShield of Tennessee, Inc., hereinafter referred to as the Contractor, is hereby amended as follows:

1. Delete Section A.2.4. in its entirety and insert the following in its place:

A.2.4 The Contractor shall assess whether all potential applicants meet the requirements for enrollment in the Plan according to the eligibility and enrollment requirements. The State reserves the authority to revise the eligibility requirements during the term of this contract. The Contractor shall utilize the following process for enrollment. The Contractor shall review each application for the requirements specified in the plan regulations or as instructed by the State and shall determine if the applicant is eligible to be a member in the plan.

- Beginning on the date the Contractor receives an application, the Contractor shall have fourteen (14) calendar days in which to make a disposition on the application. Disposition shall mean determination that the applicant does not qualify, approve the application, return the application for additional information, or refer the application to State-approved vendors for additional processing.

- If the application is determined to be incomplete, the Contractor will attempt to make the application complete by making phone calls to the applicant or physician if related to medical information. If the Contractor is unable to make contact with the applicant by phone, the Contractor will mail the applicant a postcard requesting the applicant contact the Contractor. The Contractor will return the application if there is no response from the applicant to the postcard within ten (10) business days. In such instances, the applicant may subsequently reapply for coverage.

- The days spent following up on an incomplete application will be excluded from the fourteen (14) calendar days during which the Contractor is required to make a disposition on the application.

- The Contractor shall send a letter to the applicant including an appropriate explanation of the eligibility determination and information about the appeal procedures if the applicant is found to be ineligible for the Plan. The Contractor shall issue a refund check of the initial subscriber contribution based on State established refund guidelines.

- The Contractor shall determine which provision or provisions of the Plan regulations apply to the applicant if the applicant is found to be eligible for the Plan.

- Coverage for eligible members, whose complete applications are approved on or before the 15th of the month, shall begin on the first day of the next month. Coverage for members whose complete applications are approved after the 15th of the month will begin on the first day of the second month.

2. Delete Section C.1. in its entirety and insert the following in its place:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Five Million Seven Hundred Fifty Thousand Dollars ($5,750,000.00). The Service Rates in Section C.3 shall constitute the entire compensation due the Contractor for the Service and all of the Contractor's obligations hereunder regardless of the difficulty, materials or equipment required. The Service Rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor.

The Contractor is not entitled to be paid the maximum liability for any period under the Contract or any extensions of the Contract for work not requested by the State. The maximum liability represents available funds for payment to the Contractor and does not guarantee payment of any such funds to the Contractor under this Contract unless the State requests work and the Contractor performs said work. In which case, the Contractor shall be paid in accordance with the Service Rates detailed in Section C.3. The State is under no obligation to request work from the Contractor

in any specific dollar amounts or to request any work at all from the Contractor during any period of this Contract.

3. Delete Section C.3. in its entirety and insert the following in its place:

C.3. Payment Methodology. The Contractor shall be compensated based on the rates herein for service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in Section C.1. The Contractor's compensation shall be contingent upon the satisfactory completion of units of service or project milestones defined in Section A. The Contractor shall be compensated based upon the following PMPM Rates:

PMPM Administrative Fee	PMPM 2007	PMPM 2008	PMPM 2009
AccessTN Plans (PPO)	$18.57	$18.57	$18.57
AccessTN Plan 2500 (HSA eligible HDHP)	$26.00	$26.00	$26.00

If the State, subject to a sixty (60) day notice, elects to provide for the administration of the Pharmacy Benefit (as detailed in A.10) or Disease Management (as detailed in A.9.7) or to collect premiums (as detailed in A.3) then the PMPM administrative fee shall be reduced by the associated amount detailed in the schedule below. If the adjustment takes place in the first or second year of the contract extension provided for in B.2., then the carve out reduction amounts will be increased by the same percentage that resulted from the process outlined below in C.3.1 or C.3.2.

Potential Carve Out	PMPM 2007	PMPM 2008	PMPM 2009
Reduction for Disease Management	$1.09	$1.09	$1.09
Reduction for Pharmacy	$0.78	$0.78	$0.78
Reduction for Premium Collection	$1.24	$1.24	$1.24

The Contractor shall be compensated for the application assistance service provided at a monthly rate of $4,687.50 per staff member and includes all costs associated in the provision of the service per staff member. The Contractor may be required by the State to provide up to four (4) individual staff assigned to this function on a monthly basis for the term of the Contract, but the number of staff required may be reduced by the State following discussion with the Contractor at any time should the need for the service no longer exist. The State will make a one-time payment of Five Thousand Dollars ($5,000.00) for the Contractor's expense to identify applications that had previously not qualified under the presumptive eligibility category and sending these applications for underwriting services.

The Contractor shall submit monthly invoices, in form and substance acceptable to the State with all of the necessary supporting documentation, prior to any payment. Such invoices shall be submitted for completed units of service for the amount stipulated. The State shall compensate the Contractor monthly for all services outlined in this contract, at the PMPM and other service based rates indicated, based upon the number of members certified by the Contractor to the State.

The other terms and conditions of this contract not amended hereby shall remain in full force and effect.

IN WITNESS WHEREOF:

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

Ronald E. Harr May 31, 2007

RONALD E. HARR, SENIOR VICE PRESIDENT DATE

Ronald E. Harr, Sr. Vice President

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY

ACCESS TENNESSEE BOARD OF DIRECTORS:

M. D. Goetz Jr. 6-4-07

M. D. GOETZ, JR., CHAIRMAN NOA DATE

APPROVED:

DEPARTMENT OF FINANCE AND ADMINISTRATION:

upon F&A Commissioner's signature return

M. D. GOETZ, JR., COMMISSIONER DATE

COMPTROLLER OF THE TREASURY:

John G. Morgan 6-22-07

JOHN G. MORGAN, COMPTROLLER OF THE TREASURY DATE

CONTRACT SUMMARY SHEET

8-8-05

RFS #	Contract #
350.40-044-07	FA-07-20304- 01
State Agency	**State Agency Division**
Dept. of Finance and Administration	Division of Insurance Administration
Contractor Name	**Contractor ID # (FEIN or SSN)**
Blue Cross Blue Shield of Tennessee, Inc.	☐ C- or ☒ V- 62-0427913

Service Description

To provide statewide administrative services for the AccessTN program.

Contract Begin Date	Contract End Date	SUBRECIPIENT or VENDOR?	CFDA #
February 13, 2007	December 31, 2009	Vendor	

Mark, if Statement is TRUE

☒ Contractor is on STARS as required

☒ Contractor's Form W-9 is on file in Accounts as required

Allotment Code	Cost Center	Object Code	Fund	Funding Grant Code	Funding Subgrant Code
317.86	21	891	54		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007			$604,000		$604,000
2008			$1,610,000		$1,610,000
2009			$1,610,000		$1,610,000
2010			$801,000		$801,000
TOTAL:			$4,625,000		$4,625,000

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
FY: 2007	$600,000	$4,000
FY: 2008	$1,600,000	$10,000
FY: 2009	$1,600,000	$10,000
FY: 2010	$800,000	$1,000
TOTAL:	$4,600,000.00	$25,000.00
End Date:	Dec. 31, 2009	Dec. 31, 2009

State Agency Fiscal Contact & Telephone #

John G. Anderson JM
13th Floor, Tennessee Tower
615-741-8642

State Agency Budget Officer Approval

Funding Certification (certification, required by T.C.A., § 9-4-5113, that there is a balance in the appropriation from which the obligated expenditure is required to be paid that is not otherwise encumbered to pay obligations previously incurred)

Contractor Ownership

☐ African American ☐ Disabled ☐ Hispanic ☐ Small Business ☒ NOT minority/disadvantaged
☐ Asian ☐ Female ☐ Native American ☐ OTHER minority/disadvantaged—

Contractor Selection Method

☒ RFP ☐ Competitive Negotiation ☐ Alternative Competitive Method
☐ Non-Competitive Negotiation ☐ Government ☐ Other

Procurement Process Summary

3M 26

AMENDMENT ONE
TO CONTRACT NUMBER FA-07-20304-00

The Contract, by and between the Access Tennessee Board of Directors, hereinafter referred to as the State and BlueCross BlueShield of Tennessee, Inc., hereinafter referred to as the Contractor, is hereby amended as follows:

1. Delete Section C.1. in its entirety and insert the following in its place:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Four Million Six Hundred Twenty-five Thousand Dollars ($4,625,000.00). The Service Rates in Section C.3 shall constitute the entire compensation due the Contractor for the Service and all of the Contractor's obligations hereunder regardless of the difficulty, materials or equipment required. The Service Rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor.

The Contractor is not entitled to be paid the maximum liability for any period under the Contract or any extensions of the Contract for work not requested by the State. The maximum liability represents available funds for payment to the Contractor and does not guarantee payment of any such funds to the Contractor under this Contract unless the State requests work and the Contractor performs said work. In which case, the Contractor shall be paid in accordance with the Service Rates detailed in Section C.3. The State is under no obligation to request work from the Contractor in any specific dollar amounts or to request any work at all from the Contractor during any period of this Contract.

2. Delete Section C.3. in its entirety and insert the following in its place:

C.3. Payment Methodology. The Contractor shall be compensated based on the rates herein for service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in Section C.1. The Contractor's compensation shall be contingent upon the satisfactory completion of units of service or project milestones defined in Section A. The Contractor shall be compensated based upon the following PMPM Rates:

PMPM Administrative Fee	PMPM 2007	PMPM 2008	PMPM 2009
AccessTN Plans (PPO)	$18.57	$18.57	$18.57
AccessTN Plan 2500 (HSA eligible HDHP)	$26.00	$26.00	$26.00

If the State, subject to a sixty (60) day notice, elects to provide for the administration of the Pharmacy Benefit (as detailed in A.10) or Disease Management (as detailed in A.9.7) or to collect premiums (as detailed in A.3) then the PMPM administrative fee shall be reduced by the associated amount detailed in the schedule below. If the adjustment takes place in the first or second year of the contract extension provided for in B.2., then the carve out reduction amounts will be increased by the same percentage that resulted from the process outlined below in C.3.1 or C.3.2.

Potential Carve Out	PMPM 2007	PMPM 2008	PMPM 2009
Reduction for Disease Management	$1.09	$1.09	$1.09
Reduction for Pharmacy	$0.78	$0.78	$0.78
Reduction for Premium Collection	$1.24	$1.24	$1.24

The Contractor shall submit monthly invoices, in form and substance acceptable to the State with all of the necessary supporting documentation, prior to any payment. Such invoices shall be submitted for completed units of service for the amount stipulated. The State shall compensate the Contractor monthly for all services outlined in this contract, at the PMPM rates indicated, based upon the number of members certified by the Contractor to the State.

C.3.1 If this Contract is extended pursuant to Section B.2., the following shall apply. For services performed from January 1, 2010, through December 31, 2010, the Contractor shall be compensated based upon the Service Rates fixed in Section C.3, above but the rates shall be adjusted by the percentage increase, if any, between the Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, All Items expenditure category, not seasonally adjusted, index base period: 1982-84=100) published by the United States Department of Labor, Bureau of Labor Statistics (or its successor index) in December 2009 and that figure published in the same month, 12-months prior, up to a maximum of three and one-half percent (3.5 %).

C.3.2 If this Contract is extended a second time pursuant to Section B.2., the following shall apply. For services performed from January 1, 2011, through December 31, 2011, the Contractor shall be compensated based upon the Service Rates fixed in Section C.3, above but the rates shall be adjusted by the percentage increase, if any, between the Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, All Items expenditure category, not seasonally adjusted, index base period: 1982-84=100) published by the United States Department of Labor, Bureau of Labor Statistics (or its successor index) in December 2010 and that figure published in the same month, 12-months prior, up to a maximum of three and one-half percent (3.5 %).

C.3.3 The State authorizes the Contractor to retain administrative fees, on a per patient basis, of no more than 5% of the gross recoveries received due to the subrogation activities required in A.4.11. The Contractor may retain an additional 20% of the gross recoveries, when such recoveries are made by subrogation subcontractor(s). The Contractor shall understand that recovery of subrogation claims includes claims paid as a result of work related illnesses or injuries relative to worker's compensation claims.

C.3.4 The State agrees that access fees required by the Contractor, and its licensees, for use of the BlueCard program by members covered under the Plan shall be deducted from the aggregate discount savings realized from the Blue Card Program with the savings balance accruing to the State. The maximum fees under the Blue Card program are as follows:

Type of Claim	**State's cost per Claim**
Professional Claim	$4.00
Institutional Claim	$9.75
Claim Based Access Fee Only if Charged by Host Plan	4.3% of the discount received from the Host Plan if required. Maximum of $2,000 per claim.

All other fees related to the Blue Card Program, as described in Contract Attachment G Blue Card PPO Program shall be borne by the Contractor, and should not be charged separately to the State regardless of any contrary statement in Attachment G. The State is under no obligation for any fees or compensation under the Blue Card Program other than those contained in this section.

Contractor shall provide the State with quarterly reports on the utilization of the Blue Card Program including claims paid, realized savings and Blue Card Program fees paid out of savings for the program during the quarter. Reports should be provided by the last day of the month following the quarter.

3. Delete Section E.2. in its entirety and insert the following in its place:

E. 2 Communications and Contacts. All instructions, notices, consents, demands, or other communications required or contemplated by this Contract shall be in writing and shall be made by facsimile transmission, by overnight courier service, or by first class mail, postage prepaid, addressed to the respective party at the appropriate facsimile number or address as set forth below or to such other party, facsimile number, or address as may be hereafter specified by written notice.

The State:
Ms. Marlene D. Alvarez, Manager of Procurements and Contracting
Tennessee Department of Finance & Administration
Division of Insurance Administration
312 Eighth Ave. No., 26th Floor WRS Tennessee Tower

Nashville, TN 37243-0295
Phone: 615-253-8358
Fax: 615-253-8556
Email Address: marlene.alvarez@state.tn.us

The Contractor:
Ms. Amy Bercher, Senior Product Manager
BlueCross BlueShield of Tennessee, Inc.
801 Pine Street – 4G
Chattanooga, TN 37402
Phone: 423-535-5983
Fax: 423-535-7601
E-mail Address: amy_bercher@bcbst.com

with a copy to:
Associate General Counsel
BlueCross BlueShield of Tennessee, Inc.
801 Pine Street
Chattanooga, TN 37402
Attention: Associate General Counsel
Fax: 423-535-1984

All instructions, notices, consents, demands, or other communications shall be considered effectively given as of the day of delivery; as of the date specified for overnight courier service delivery; as of three (3) business days after the date of mailing; or on the day the facsimile transmission is received mechanically by the telefax machine at the receiving location and receipt is verbally confirmed by the sender if prior to 4:30 p.m. CST. Any communication by facsimile transmission shall also be sent by United States mail on the same date of the facsimile transmission.

4. Delete Attachment D, AccessTN Benefit Summary, in its entirety and insert the following in its place:

Attachment D
AccessTN Benefit Summary

AccessTN OUTLINE OF PPO MEDICAL BENEFITS	**Plan 1000 "premium-assistance eligible"**	**Plan 2500 "HSA-eligible" HDHP**	**Plan 5000 "Catastrophic"**
This listing is for illustration only; plan documents shall control.	**Note: Benefits are subject to change by the AccessTN Board of Directors.**		
PREVENTIVE CARE (annual well-woman exam & / or health assessment exam with specified lab and diagnostic services)	100% in-network	100% in-network	100% in-network
The above is first dollar in-network coverage for wellness care such as an annual physical, not subject to deductible or co-insurance.			
DEDUCTIBLES Individual Maximum Deductible per Plan Year In network Out-of-network	$1,000 $2,000	$2,500 $2,500	$5,000 $10,000
Covered Expenses, as specified plan document, subject to maximum allowable charge	80% in-network 60% out-of-network	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Pre-Existing Conditions Period- except as stated for specific benefits, to be determined by Board of Directors	6 months	6 months	6 months
Prescription Drugs - Pharmacy does not apply to out of pocket maximum except for Plan 2500 – HSA	No deductible for outpatient drugs	Deductible applies to drugs	No deductible for outpatient drugs

AccessTN **OUTLINE OF PPO MEDICAL BENEFITS**	**Plan 1000** **"premium-assistance eligible"**	**Plan 2500** **"HSA-eligible" HDHP**	**Plan 5000** **"Catastrophic"**
Retail up to 34 day supply. Up to 102 day supply through home delivery, including retail pharmacies that agree to the same terms and conditions as a home delivery pharmacy. Self-administered Specialty Pharmacy products limited to a 30 day supply.			
Generic	$10 copayment (or cost if less)	Covered under deductible, coinsurance and out-of-pocket limit to meet federal guidelines for an HSA eligible plan.	$15 copayment (or cost if less)
Preferred Brand Drugs	25% coinsurance subject to a min. of $25, max. of $50		30% coinsurance subject to a min. of $30, max. of $75
Non-Preferred Brand	50% coinsurance subject to a min. of $50, max. of $100	Non-preferred brands are not covered.	60% copayment subject to a min. of $60, max. of $150
Non-Covered Drugs	as identified by formulary	Any drugs not identified by formulary as covered	as identified by formulary
Maximum Out-of-Pocket Expense (does not apply to pharmacy – except for Plan 2500, to out-of-network services, or to co-pays for emergency room)	$5,000	$5,000	$10,000
Maximum Annual Benefits, except for supplemental Organ Transplants as below	$120,000	N/A	$100,000
Supplemental Maximum Benefit for Transplants	$100,000	$100,000	$100,000
Maximum Lifetime Benefits Subject to prior benefits incurred in another state high risk pool(s)	$1,000,000	$1,000,000	$1,000,000
Covered Services include			
Inpatient services - non-emergent service must be preauthorized	80% in-network 60% out-of-network	80% in-network 60% out-of-network Limited to 45 days per year	80% in-network 60% out-of-network
Surgical Procedures Diagnostic Lab and Imaging Services Physician office visits Preventive care other than those services specified above in Preventive Care allowance Chemotherapy and Radiation Therapy Organ Transplant (designated procedures) Provider Administered Specialty Pharmacy	80% in-network 60% out-of-network	80% in-network 60% out-of-network	80% in-network 60% out-of-network

AccessTN OUTLINE OF PPO MEDICAL BENEFITS	Plan 1000 "premium-assistance eligible"	Plan 2500 "HSA-eligible" HDHP	Plan 5000 "Catastrophic"
Maternity benefits	Subject to 12 month waiting period	Subject to 12 month waiting period	Subject to 12 month waiting period
Approved/Accredited Rehabilitation Facility			
Covered services listed below	80% in-network 60% out-of-network	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Inpatient Rehabilitation Facility		Limited to 45 days per year	
Outpatient Rehabilitation Facility	Limited to 45 days per year	Limited to 45 days per year	Limited to 45 days per year
Skilled Nursing Facility (Following approved hospitalization. Prior authorization required.)	Limited to 45 days per year	Limited to 45 days per year	Limited to 45 days per year
Home Health Care	30 visits per year	30 visits per year	30 visits per year
Non-Hospital & Non-Physician Services			
Independently Practicing Physical Therapists, Speech Therapists, Occupational Therapists, Dialysis Clinics, Oral Surgeons, or Audiologists	80% in-network 60% out-of-network	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Non-Contracted Providers (Varies based on the network/services area outside of Tennessee)	(Varies based on the network/services area outside of Tennessee)	(Varies based on the network/services area outside of Tennessee)	(Varies based on the network/services area outside of Tennessee)
Emergency Services (in-state or out-of-state)			
Emergency services (in -network or out-of-network) Note: Out-of-network benefits will be reduced to non-PPO levels if the claims administrator determines the situation was not an emergency.	80% of reasonable charges	80% of reasonable charges	80% of reasonable charges
Emergency Room Visit Copayment waived if admitted; Note: copayment required even if out-of-pocket expenses have been met	$50 copayment per use	Not applicable	$75 copayment per visit
Non-Emergent/Urgent Care			
Urgent Care Situations Urgent Care received at a walk-in clinic	80% in-network 60% out-of-network	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Urgent Care received through hospital emergency room (in addition to ER copay)	80% in-network 60% out-of-network	80% in-network 60% out-of-network	80% in-network 60% out-of-network

AccessTN OUTLINE OF PPO MEDICAL BENEFITS	Plan 1000 "premium-assistance eligible"	Plan 2500 "HSA-eligible" HDHP	Plan 5000 "Catastrophic"
Appliances & Equipment Durable Medical Equipment	80% in-network 60% out-of-network $3,000 Annual Max	80% in-network 60% out-of-network $3,000 Annual Max	80% in-network 60% out-of-network $3,000 Annual Max
EXCLUSIONS (This is a partial list- includes any services not medically necessary, etc.; see plan document for complete listing of exclusions.)	Cosmetic procedure Human Growth Hormone Hearing aids Eyeglasses, contacts, etc. Dental services Routine foot care Assisted reproductive technology, including fertility drugs Services or supplies related to obesity, including surgical or other treatment for morbid obesity		
SCHEDULE OF PPO MENTAL HEALTH/ SUBSTANCE ABUSE BENEFITS			
DEDUCTIBLES- No separate Mental Health deductible	Outpatient services not subject to plan deductible	All services subject to health plan deductible	Outpatient services not subject to plan deductible
COINSURANCE for Mental Health/ Substance Abuse	See below	After $2500 plan deductible met	See below
Inpatient – Including Intermediate Care Services (the preauthorization process must be followed or benefits are reduced to 50% of the MAC of the 80/60% levels)	80% in-network 60% out-of-network 30 days	80% in-network 60% out-of-network 30 days	80% in-network 60% out-of-network 30 days
Outpatient- In- Network Out-of-Network, subject to MAC [Note- Outpatient therapy sessions are NOT subject to plan deductible; Inpatient above and intermediate levels below are subject to deductible.]	80% in-network 60% out-of-network 45 sessions	80% in-network 60% out-of-network 45 sessions	80% in-network 60% out-of-network 45 sessions
Expenses determined not to be medically necessary by the utilization review organization	$0	$0	$0

Intermediate Care

All intermediate levels of care will be counted as inpatient for purposes of plan limitations.

- Residential Treatment: defined as a 24-hour level of residential care that is medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. 1.5 residential treatment days = 1 inpatient day
- Partial Hospitalization: defined as structured and medically supervised day, evening and/or night treatment programs where program services are provided to patients at least 4 hours/day and are available at least 3 days/week, although some patients may need to attend less often. 2 partial hospitalization days = 1 inpatient day.

- Intensive Outpatient: defined as an intensive outpatient program, usually comprised of coordinated and integrated multidisciplinary services, having the capacity for a planned, structured, service provision of at least 2 hours per day and 3 days per week, although some patients may need to attend less often.
- 5 structured outpatient days = 1 inpatient day

Substance Abuse Limitations

- Lifetime maximum: Two inpatient stays – maximum of 28 days per stay. A stay is any substance treatment counted as inpatient (including intermediate levels of care) where the duration is between 1 inpatient day and 28 inpatient days.
- Lifetime maximum: Two inpatient stays for detoxification – maximum of 5 days per stay. A stay is any detox treatment counted as inpatient (including intermediate levels of care) where the duration is between 1 inpatient day and 5 inpatient days.

Additional Mental Health Limitations

- Inpatient care limit of 30 days per plan year (intermediate levels of care will be considered inpatient treatment for purposes of this limitation).
- Outpatient care limit of 30 visits per plan year is for mental health/substance abuse combined.

Payment is based on the MAC. Covered persons will be responsible for the deductible and any applicable copayment or coinsurance amounts. If non-network providers are used, covered persons will also be responsible for payment of charges above the Mac.

4. Add the following as Section E.12 and renumber any subsequent sections as necessary:

E.12 High Deductible Health Plan Option. One of the AccessTN PPO Plans offered by the State is a High Deductible Health Plan (HDHP), a type of plan that has a higher calendar year deductible than a typical health plan and intended to be eligible for use with a Health Savings Account (HSA). If choosing the HDHP option, a Member may qualify for tax savings by contributing to a HSA. An HSA is a personal tax-exempt trust or custodial account used to pay for qualified medical expenses, which is regulated by the Internal Revenue Service. The parties expressly acknowledge and agree that (i) neither party will provide an HSA as part of the AccessTN PPO HDHP option; (ii) neither party will provide a Member with tax advice; and (iii) Contractor does not make (and the State has not relied upon) any representation, warranty or statement regarding a Member's qualification for an HSA in conjunction with choosing the HDHP option.

The other terms and conditions of this contract not amended hereby shall remain in full force and effect.

IN WITNESS WHEREOF:

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

Ronald E. Harr — May 4, 2007

RONALD E. HARR, SENIOR VICE PRESIDENT — **DATE**

Ronald E. Harr, Sr. Vice President

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY

ACCESS TENNESSEE BOARD OF DIRECTORS:

M. D. Goetz, Jr. — 5-8-07

M. D. GOETZ, JR., CHAIRMAN — **DATE**

APPROVED:

DEPARTMENT OF FINANCE AND ADMINISTRATION:

per authorized signature above

M. D. GOETZ, JR., COMMISSIONER DATE

COMPTROLLER OF THE TREASURY:

6-22-07

JOHN G. MORGAN, COMPTROLLER OF THE TREASURY DATE

CONTRACT SUMMARY SHEET

8-8-05

RFS #	Contract #
350.40-044-07	FA-07-20304-00

State Agency	State Agency Division
Dept. of Finance and Administration	Division of Insurance Administration

Contractor Name	Contractor ID # (FEIN or SSN)	
Blue Cross Blue Shield of Tennessee, Inc.	☐ C- or ☒ V-	62-0427913

Service Description

To provide statewide administrative services for the AccessTN program.

Contract Begin Date	Contract End Date	SUBRECIPIENT or VENDOR?	CFDA #
February 13, 2007	December 31, 2009	Vendor	

Mark, if Statement is TRUE

☒ Contractor is on STARS as required

☒ Contractor's Form W-9 is on file in Accounts as required

Allotment Code	Cost Center	Object Code	Fund	Funding Grant Code	Funding Subgrant Code
317.86	#21	98891	54		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2007			$600,000		$600,000
2008			$1,600,000		$1,600,000
2009			$1,600,000		$1,600,000
2010			$800,000		$800,000
TOTAL			$4,600,000		$4,600,000

COMPLETE FOR AMENDMENTS ONLY

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
FY: 2007		
FY: 2008		
FY: 2009		
TOTAL		
End Date		

State Agency Fiscal Contact & Telephone #

John G. Anderson
13th Floor, Tennessee Tower
615-741-8642

State Agency Budget Officer Approval

Funding Certification (certification required by T.C.A. § 9-4-5113 that there is a balance in the appropriation from which the obligated expenditure is required to be paid that is not otherwise encumbered to pay obligations previously incurred)

Contractor Ownership

☐ African American ☐ Disabled ☐ Hispanic ☐ Small Business ☒ NOT minority/disadvantaged

☐ Asian ☐ Female ☐ Native American ☐ OTHER minority/disadvantaged—

Contractor Selection Method

☒ RFP ☐ Competitive Negotiation ☐ Alternative Competitive Method

☐ Non-Competitive Negotiation ☐ Government ☐ Other

Procurement Process Summary

COMPTROLLER'S OFFICE
OFFICE OF
MANAGEMENT SERVICES

RECEIVED
2007 FEB 27 AM 10:06

FEB 30

CONTRACT
BETWEEN THE STATE OF TENNESSEE,
ACCESS TENNESSEE BOARD OF DIRECTORS
AND
BLUECROSS BLUESHIELD OF TENNESSEE, INC.

This Contract, by and between the Access Tennessee Board of Directors, hereinafter referred to as the "State" and BlueCross BlueShield of Tennessee, Inc., hereinafter referred to as the "Contractor," is for the delivery of AccessTN Self Insured Health Plan Services, including: provider network development and maintenance, eligibility and enrollment, premium billing and collection, medical and care management, disease management, pharmacy benefits, customer service, claims adjudication, maintain an appeals process, financial and program reporting for the AccessTN (PPO) plan option in Tennessee; and as further defined in the "SCOPE OF SERVICES."

The Contractor is a for profit corporation.

The Contractor's address is:

BlueCross BlueShield of Tennessee, Inc.
801 Pine Street – 4G
Chattanooga, TN 37402

The Contractor's place of incorporation or organization is Tennessee.

The Contractor's Federal Employee Tax Identification Number is 62-0427913.

A SCOPE OF SERVICES

The Contractor agrees to provide administrative services for the AccessTN self-insured PPO option for eligible AccessTN members who elect to participate in the AccessTN option offered by the Contractor, hereinafter referred to as "eligible AccessTN members", in accordance with the terms of this agreement.

The Contractor is responsible for providing administrative claims payment services in accordance with the terms of the Plan, its duties and services as described in Attachment D, AccessTN Benefit Summary, and other duties specifically assumed by it pursuant to this Contract. Contractor does not assume any financial risk or obligation with respect to Plan claims.

Definitions:

- **"Eligible Individuals"** are defined as individuals who meet two sets of eligibility criteria. The individual must be "uninsurable", which can be established by any one of three methods:
  1. Declination letters from two unaffiliated carriers offering individual health insurance in Tennessee (note: this must be from the company and not from a broker or agent);
  2. A doctor's statement, with specific CPT code or ICD-9 information, that the applicant has one of the presumptive medical conditions approved by the Board, and which are subject to change by the Board; and,
  3. Qualification through underwriting by an AccessTN vendor, using the health history of the applicant and supplemental medical records as necessary.

  And the individual must meet the following conditions:
  - Be a United States citizen
  - Be a resident of Tennessee for at least the last six months
  - Have used up any continuation of coverage, including COBRA, available when group health insurance terminated
  - Not have access to other health insurance at the time application is submitted
  - Not have had health insurance within the last six months.

- **"Members"** are defined as AccessTN eligible individuals who are enrolled in the PPO option offered by the Contractor.

A.1 PREFERRED PLAN ORGANIZATION PROVIDER NETWORK

A.1.1 The Contractor shall maintain and administer an AccessTN Plan provider network covering the entire State of Tennessee service area, for plan subscribers, in accordance with this contract. The Contractor further agrees to maintain under contract, participation by health care providers including but not limited to primary care physicians, specialist physicians, nurse practitioners/physician assistants, hospitals (all levels primary, secondary and tertiary), Centers of Excellence for high risk/high cost procedures, nursing homes, laboratories, pharmacies and all other health care facilities, services and providers necessary to provide high quality, cost effective services, adequate distribution, and reasonable access from a geographic and service standpoint throughout the State of Tennessee.

A.1.1.1 As required by Contract Attachment A, Performance Guarantees # 6 (Provider/Facility Network Accessibility), the State shall monitor network access. When requested by the State, the Contractor shall, within 10 business days and in writing, report to the State any actions it intends to take to correct any deficiencies highlighted by annual network reports.

A.1.2 The Contractor shall maintain a network of specialized providers (Centers of Excellence) for the provision of service of high cost/high risk and specialization. Centers of Excellence criteria for provider inclusion within the network shall be based on price, quantity, quality, and patient outcome, as described in the Contractor's Proposal. The Contractor shall also develop specific criteria for Centers of Excellence referrals and follow-up.

A.1.3 The Contractor shall report to the State within five working days of the end of each contract quarter any changes in the designation of network hospitals, physicians, and other health care providers, but no less than thirty (30) calendar days prior to the removal of a hospital, clinic or ambulatory surgery center from the network.

A.1.4 The Contractor cannot take action to disenroll network primary care providers or hospital providers for one (1) year beginning each January 1, except for good reason, which may include: inability to negotiate continuance of its provider agreement; provider failure in the credentialing/re-credentialing process; non-compliance with contract requirements; provider request for disenrollment; member complaints; suspicion of provider impairment; loss of license or exclusion from participation in Medicare or Medicaid pursuant to Sections 1128 or 1156 of the Social Security Act.

A.1.5 The Contractor, following review and approval by the State, shall, update, print and distribute to subscribers' homes benefits information and provider directories as required by the State. The benefits information and provider directories may be printed as separate documents. The booklet must be AccessTN-specific and shall include a Summary Plan Description describing PPO premiums, benefits and exclusions, the Contractor's network of providers, and the Drug Formulary. Distribution shall be made to every subscriber upon Enrollment. "Enrollment: shall be defined as the date Contractor determines that an applicant is eligible and enters the applicant's data into Contractor's core processing system. At the discretion of the State, the directory may include provider name, specialty, address and phone number and can be organized in geographic areas as small as counties. Said booklets shall be updated and distributed to subscribers' homes at least annually. The costs associated with printing and distribution of said booklets is the sole responsibility of the Contractor. Upon mutual agreement of the State and the Contractor, electronic means may be utilized to inform members of the network of providers.

A.1.6 The Contractor shall maintain the capability to respond to inquiries from participants concerning participation by providers in the network, by specialty and by county. Such capability shall be by toll-free telephone and an up-to-date internet based directory of providers that includes provider search capability.

A.1.7 The Contractor shall ensure that the AccessTN Plan and its members financially benefit from any contracts maintained between the Contractor and health care providers. All special pricing considerations and financial incentives shall accrue to the AccessTN PPO and its plan participants

through the provision of plan benefits or upon the use of the network in the event that the member exceeds the annual benefit limit.

A.1.8 The Contractor shall ensure that network health care providers only bill members for applicable PPO plan benefit co-payments and coinsurance amounts.

A.1.9 The Contractor shall contract only with health care providers who are duly licensed to provide such medical services. In addition, the Contractor shall require that all providers maintain all licenses and accreditations in existence at the time of selection as a network provider in order to continue their status as a network provider. The Contractor shall perform on a continuous basis, appropriate provider credentialing as described in the Contractor's Proposal that assures the quality of network providers. Re-credentialing of network providers must be performed at least every three years.

A.1.10 The Contractor shall maintain communication with providers to ensure a high degree of continuity in the provider base and ensure that the providers are familiar with the PPO plan benefit requirements. There must be provisions for face-to-face contact in addition to telephone and written contact between Contractor and network health providers. Additionally, the Contractor must review and assess the practice patterns of network providers consistent with evidence based medicine, share its findings with network providers and take measures to maintain a quality, efficient and effective network of providers.

A.1.11 The Contractor shall notify all network providers of and enforce compliance with all provisions relating to utilization management, care management, and case management procedures, and other services as required for participation in the PPO provider network.

A.1.12 The Contractor shall require all network providers to file claims associated with their services directly with the Contractor on behalf of plan members.

A.1.13 The Contractor shall identify and sanction network providers who establish a pattern of referral to non-network providers.

A.1.14 The Contractor will quarterly notify the State in writing prior to any adjustments to provider fee schedules, facility per diems, DRG payments, capitated arrangements, or other provider payment arrangements, and the manner in which such adjustments will impact the cost of claims payments for the PPO plan. As part of any changes in future provider reimbursement methods, the State would be willing to explore the use of any Contractor proposed methods of payment that include provider incentives based on valid and reliable performance measures in areas such as clinical performance, patient satisfaction, and use of information technology.

A.2 ELIGIBILITY AND ENROLLMENT SERVICES

A.2.1 The Contractor shall be responsible for administering the AccessTN plan benefits and exclusions as developed and approved by the State on the plan effective date. Within six (6) months of the contract effective date, the Contractor shall develop and maintain the capability to electronically scan applications and accompanying documents and securely transfer them to the Health Underwriting vendor and the Premium Assistance vendor. The transfer may take place by access to a secure internet connection, secure email or other HIPAA compliant means.

A.2.2 The Contractor shall develop an application and information brochure detailing coverage options for the AccessTN Plan. The information brochure developed by the Contractor shall be subject to the State's approval. The application should request all information necessary for determination of eligibility so that no additional information will be required of applicants. Once approved by the State, the Contractor shall produce sufficient copies of the Application form and brochure to meet information requests and inquiries by the public.

A.2.3 The Contractor shall develop an AccessTN PPO subscriber identification card to be distributed to Plan members upon Enrollment.

A.2.4 The Contractor must assess whether all potential applicants meet the requirements for enrollment in the Plan according to the eligibility and enrollment requirements. The State reserves the authority to revise the eligibility requirements during the term of this contract. The Contractor shall utilize the following process for enrollment:

- The Contractor shall review each application for the requirements specified in the plan regulations or as instructed by the State and shall determine if the applicant is eligible to be a member in the plan.

- Beginning on the date the Contractor receives an application, the Contractor shall have fourteen (14) calendar days in which to make a disposition on the application. Disposition shall mean either decline the application, approve the application, return the application for additional information, or refer the application to State-approved vendors for additional processing. If the application is determined to be incomplete, the Contractor will attempt to make the application complete by sending written notification to the applicant detailing what is needed to complete the application, however,. the application shall be considered withdrawn. In such instances, individuals may subsequently reapply for coverage.

- The Contractor shall send a letter to the applicant including an appropriate explanation of the eligibility determination and information about the appeal procedures if the applicant is found to be ineligible for the Plan. The Contractor shall issue a refund check of the initial subscriber contribution based on State established refund guidelines.

- The Contractor shall determine which provision or provisions of the Plan regulations apply to the applicant if the applicant is found to be eligible for the Plan.

- Coverage for eligible members, whose complete applications are approved on or before the 15th of the month, shall begin on the first day of the next month. Coverage for members whose complete applications are approved after the 15th of the month will begin on the first day of the second month.

A.2.5 The Parties understand that there may on occasion be more applicants than available program openings, or "slots". The State, or an entity acting on the State's behalf, shall develop, maintain and implement an intake and enrollment processing procedure, which will utilize random selection processing, when there are more applications than available program slots. Contractor agrees to provide to the State, or the entity acting on behalf of the State, a list of applicants eligible for enrollment in the AccessTN program and other information necessary to perform the random selection processing. Contractor further agrees to process the applications for the AccessTN program in the order provided by the State or the entity acting on behalf of the State.

A.3 PREMIUM BILLING, COLLECTION AND TERMINATION FOR NONPAYMENT

A.3.1 The Contractor shall be capable of collecting the appropriate premium amounts from plan members. The State will establish a schedule of premium amounts based upon age, tobacco use and body mass index (BMI), involving no more than ten (10) age based levels.

A.3.2 The Contractor shall maintain accurate records of earned and unearned premiums received and premium refunds.

A.3.3 The Contractor shall send billing statements to members at their home address and collect all premium payments in a time and manner consistent with State policy.

A.3.4 The Contractor shall maintain the ability to receive information and funds from a premium assistance program for AccessTN members. The premium assistance program will be administered by a separate contractor and the transmittal of information concerning the recipients of the assistance will take place on a monthly basis and shall accommodate the AccessTN billing cycle.

A.3.5 The Contractor shall report premiums collected to the State on a monthly basis, and deposit all premium funds to the designated AccessTN account in a time and manner consistent with State policy and procedures

A.3.6 The Contractor shall implement a notification process concerning premiums due on a monthly basis and a process to suspend and subsequently terminate coverage for individuals who fail to pay premium in a timely fashion. The process shall assure that:

a. Premium billings are consistently generated on a date agreed upon by the State,
b. Premiums are due from members by the 1st day of each month of member coverage, unless mutually agreed upon by the Contractor and the State,
c. Medical benefit payments are suspended when members fail to pay premiums by the due date designated,
d. Pharmacy payments are suspended concurrent with the Contractor's standard corporate processes when members fail to pay premiums by the due date designated,
e. Members who do not remit premium payment in accordance with payment policies are promptly terminated effective to the last date for which premiums were paid, and
f. There is a reinstatement policy in place for members who were terminated from AccessTN coverage due to failure to pay premiums on a timely basis, subject to approval by the State.

The State may require no greater than four (4) notifications for the proper administration of premium payments and collection.

A.4 CLAIMS AJUDICATION

A.4.1 The Contractor shall by the contract start date, establish administrative claim processing and payment functions on behalf of the State from receipt of both paper and electronic claims, through final payment or denial on a fully automated claim adjudication system in a timely and accurate manner and all other necessary functions to assure timely adjudication of claims and payment of benefits to eligible members under the Plan.

A.4.2 The Contractor shall ensure the claims processing function is operated and maintained in an efficient and effective manner. The system shall have at a minimum the following capabilities:

(a) automated eligibility verification that coverage has not terminated on the date of eligible service;
(b) benefit plan information stored on the system;
(c) automatic calculation of deductibles, co-insurance out-of-pocket limits, and annual or lifetime maximum accumulations;
(d) automated calculation of cost containment provisions;
(e) identification and collection of claim overpayments and
(f) automated tracking of internal limits.

A.4.3 The Contractor shall be responsible for making available information relating to the proper manner of submitting a claim for benefits to the Plan and distributing forms upon which claim submissions shall be made, or making provision for the acceptance and processing of electronically-filed claims.

A.4.4 The Contractor shall process all medical claims in strict accordance with the AccessTN Plan Document and its clarifications and revisions. The Contractor may not modify these benefits during the term of this contract without the approval of the State.

A.4.4.1 Upon request by the State, the Contractor shall modify its benefits administration system to reflect approved Plan benefit amendments (new, changed, or cancelled) within 30 days of notification by the State. Should said benefit amendment(s) not be effective within 30 days, the Contractor shall have until the effective date of the amendment to modify its benefits administration system.

A.4.5 The Contractor shall, upon payment of a claim, provide an Explanation of Benefits (EOB) notice to the AccessTN plan member. The EOB shall include the name of the patient, the provider, the date(s) of service, payments to the provider and the patient's liability.

A.4.6 The Contractor shall ensure that the majority of claims will be paperless for the members. Providers will have the responsibility through their contract with the Contractor to submit claims directly to the Contractor.

The Contractor shall ensure that the electronic data processing (EDP) environment (hardware and software), data security, and internal controls meet all present standards, and will meet all future standards, required by the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191. Said standards shall include the requirements specified under each of the following HIPAA subsections:

Electronic Transactions and Code Sets
Privacy
Security
National Provider Identifier
National Employer Identifier
National Individual Identifier
Claims attachments
National Health Plan Identifier
Enforcement

The Contractor shall maintain an EDP and electronic data interface (EDI) environment that meets the requirements of this contract and meets the privacy and security requirements of the Health Insurance Portability and Accountability Act of 1996. The Contractor must have a disaster recovery plan for restoring the application software and current master files and for hardware backup if the production systems are destroyed.

A.4.7 To maintain the privacy of personal health information, the Contractor shall provide to the State a method of securing email for daily communications between the Division of Insurance Administration and the Contractor.

A.4.8 The State shall have the sole responsibility for and authority to clarify and/or revise the AccessTN PPO benefits available under this program. It is understood between the parties that the program cannot and does not cover all medical situations. In a case where the benefits are not referenced in the AccessTN Plan Document or are not clear, the Contractor shall utilize their standard polices in adjudicating claims including medical necessity determination, and the Contractor shall advise the State in writing, as to the difference along with the Contractor's recommendation. Such matters as determined by the State to have a significant impact on administration of plan benefits shall be resolved by the State.

A.4.9 To ensure the efficient and timely processing of claims and the adequate capture of data, the Contractor shall provide members with AccessTN identification cards. Identification cards shall contain unique identifiers for each member; such identifier shall NOT be the member's Federal Social Security Number. The cost of these items shall be borne by the Contractor. The State reserves the authority to review and approve any claim forms and identification cards prior to issuance for use. Contractor shall update enrollment and shall mail participant I.D. cards no later than fourteen (14) calendar days from Enrollment.

A.4.10 The Contractor shall have in place a process providing for the coordination of benefits based on AccessTN as the payor of last resort.

A.4.11 The Contractor shall institute subrogation based on a mutually agreeable process between the Contractor and the State. Such process shall include:

- A defined process for the recovery of monies received through subrogation;
- Notification, upon request by the State, of the status of cases under review for subrogation and
- Identification to the State of all subrogation subcontractors and, upon request by the State, copies of said subcontracts.

Additional information regarding the retention of administrative fees by the Contractor is included in Section C.3.3 of this contract.

A.4.12 The Contractor shall determine eligible expenses which are medically necessary. The Contractor must have on staff qualified and licensed medical personnel whose primary duties are to determine both prospectively and retroactively the medical necessity of treatments and their associated claims.

A.4.13 The Contractor shall have a process in place based on the most appropriate up to date clinical and pharmacological information for determining those procedures and services that are considered experimental/investigative. The Contractor shall provide to the State within 15 days of contract implementation detailed information on the Contractor's process for determining experimental/investigational procedures and services.

A.4.14 The Contractor shall notify the State, within thirty (30) days of a retroactive termination, of all claims paid on behalf of the affected plan member during the period covering the retroactivity. The State will notify the Contractor to initiate the recovery of claims.

A.4.15 Upon conclusion of this contract, or in the event of its termination or cancellation for any reason, the Contractor shall be responsible for the processing of all claims incurred for medical services rendered or medical supplies purchased during the period of this contract with no additional administrative cost to the State. The claims run out period shall extend through the final day of the thirteenth (13^{th}) month following contract termination.

A.4.16 The Contractor shall assist the State in identifying fraud and perform fraud investigations of members and providers, in consultation with the State, for the purpose of recovery of overpayments due to fraud. Reviews must include all possible actions necessary to locate and investigate cases of potential, suspected, or known fraud and abuse. In the event the Contractor discovers evidence that an unusual transaction has occurred that merits further investigation, the Contractor shall inform the Division of Insurance Administration, the Division of State Audit, in the Office of the Comptroller of the Treasury and the State of Tennessee Office of inspector General. The State will review the information and inform the Contractor whether it wishes the Contractor to:

- discontinue further investigation if there is insufficient justification; or
- continue the investigation and report back to the Division of Insurance Administration, the Office of the Inspector General and the Division of State Audit; or
- continue the investigation with the assistance of the Division of State Audit; or
- discontinue the investigation and turn the Contractor's findings over to the Division of State Audit for its investigation.

A.5 CLAIMS PAYMENT AND RECONCILIATION PROCESS

A.5.1 For the payment of all claims under this contract, the Contractor shall issue payments in the form of checks and/or Automated Clearing House (ACH) electronic funds transfer against the Contractor's own bank account. Unless otherwise mutually agreed to in writing by the parties, the check mailing/delivery process, including the location and timing for the printing and mailing of the checks shall be in the manner described in the Contractor's Proposal. The Contractor shall maintain security and quality controls over the design, printing and mailing of checks, as well as any fraud prevention feature of check stock in the manner described in the Contractor's Proposal.

A.5.2 The State shall fund the Contractor for the total issue amount of the payments, net of cancellations, voids or other payment credit adjustments, daily or at the time of each issuance of checks or ACH, provided the Contractor's payment process includes timely delivery of checks and settlement of ACH transactions. Unless otherwise mutually agreed to in writing by the parties, the Contractor shall notify the State of the day's funding requirement amount in the manner described in the Contractor's Proposal. The funding option for the State shall include either receiving an ACH debit from the Contractor to a designated State bank account, or wire transfer of funds to the Contractor's designated bank account. The parties shall mutually agree upon the funding option. The Contractor acknowledges and agrees that since the State intends to fund payments at the time of issuance, the State shall not maintain a separate bank account or an escrow account with the Contractor or to otherwise pre-fund an account.

A.5.3 The Contractor further acknowledges the State will monitor and age the outstanding check balance and the Contractor agrees, upon request of the State, to conduct a review and/or cancel-reissue of stale dated outstanding items. In a format mutually agreed to, the Contractor on a daily basis, shall provide a detailed listing of the payment activity, including check serial numbers and ACH payment identifiers, payee names and payment amounts balancing to the required funding amount for that day. Said listing shall enable the State to reconcile the payment detail to the required funding amount, while providing related payment information needed to record the necessary accounting entries by expense classifications. The Contractor shall further provide monthly check Reconciliation Reports that provide detail (check number, issue date, payee name, claim numbers, check amount, paid or cancel date) of all checks issued or cancelled during the month, and detailed listing of outstanding checks at each month-end. At the specific request of the State, the Contractor shall provide in an electronic file, information which provides both payment information and claim numbers.

A.5.4 The Contractor shall issue all related Internal Revenue Service (IRS) Form 1099 reports, submit required 1099 information directly to the IRS utilizing Contractor's tax ID number, and shall maintain responsibility in matters relating to such information provided to payees and to the IRS, including the payment of any penalties or fees related to such 1099 reporting.

A.5.5 Overpayments resulting from the negligent, reckless, or willful acts or omissions of the Contractor, its officers, agents or employees shall be the responsibility of the Contractor, regardless of whether or not such overpayments can be recovered by the Contractor. The Contractor shall repay the State the amount of any such overpayment within thirty (30) calendar days of discovery of the overpayment. Overpayments due to provider fraud or fraud of any other type, other than fraud by employees or agents of the Contractor, will not be considered overpayments for purposes of this Section. The Contractor agrees to assist in identifying fraud and make reasonable efforts, in consultation with the State, to recover overpayments due to fraud. The State will not hold the Contractor responsible for overpayments caused by the State's errors or errors caused by any other agency or department of the State of Tennessee; however, the Contractor shall assist the State in recovery of such overpayments. The requirement that the Contractor assist the State in identifying or recovering overpayments as provided in this Section does not require the Contractor to become a party to any legal proceeding as a result thereof.

A.6 FINANCIAL TRACKING AND REPORTING

A.6.1 The Contractor shall establish a financial accounting system and/or methods employed by the Contractor that leave a clear audit trail of all financial transactions and records executed and maintained by the Contractor on behalf of the Plan. The Contractor shall maintain all financial records consistent with sound business practices and based upon generally accepted United States accounting principles, and shall clearly identify all revenue and disbursements by type of transaction. The Contractor at a minimum will be responsible for determining net written and earned premiums, other state and federal funding received by the pool, the expense of administration, the paid and incurred losses for the year and any other business conducted on behalf of the Plan and requested by the State, for each quarter and calendar year. Such information shall be reported to the State and to the State of Tennessee Comptroller of the Treasury in a form and manner prescribed by the Commissioner of Finance and Administration.

A.6.2 The Contractor will maintain a general ledger and supporting accounting records and systems for the Plan that are adequate to meet the needs of an insurance carrier of comparable size. This will include, but is not limited to:

(a) preparation and reconciliation of monthly financial statements on a cash basis in a format prescribed by the State;
(b) preparation of accrual based quarterly financial statements prepared in accordance with statutory and/or generally accepted accounting principles prescribed

A.6.3 The Contractor shall;

(a) Establish and maintain a management information reporting system that provides enrollment utilization, claims reporting, and administrative services data to the State;
(b) The Contractor shall retain and maintain all records and documents in any way relating to the Plan for **three years** after final payment by the State or any applicable statute of limitations, whichever is longer, and shall make them available for inspection and audit by authorized representatives of the State, including the State or the State's designee, at all reasonable times. ~~All records related in any way to the Plan are to be retained for the entire time provided under~~ this section.

A.7 GENERAL ADMINISTRATION

A.7.1 The Contractor shall by February 15, 2007, establish and provide a customer service operation that is available to plan members from at least 8:00 a.m. to 6:00 p.m. EST. Monday through Friday (excluding holidays). The customer service operation should also include a state wide, toll-free customer service line equipped with an automated voice response system that members can access directly 24 hours a day, 7 days a week, to request and receive service authorizations or other pertinent data.

A.7.2 The Contractor shall also establish and maintain a dedicated state-wide toll-free fax number for applicants to submit enrollment, and claim materials, as well as supporting documents. This toll-free fax number must receive application materials on a secured fax server. Claim forms (if required) must be mailed to members within two (2) business days from the date of request.

A.7.3 The Contractor shall provide a customer service operation that includes:

(a) Qualified staff available to answer questions on benefits, benefit levels, and claims procedures. Disabled individuals must be provided adequate access to the customer service system;
(b) An information system capable of electronically transmitting, receiving, and updating member profile information regarding demographics, coverage, and other information (e.g. eligibility, change of address, etc.) from the Administrative Services Contractor;
(c) A toll-free line abandon rate not to exceed five percent (5%) of incoming calls (or the Contractors standard abandon rate, if so specified) in a calendar month. The abandon rate percentage shall be calculated using the hourly abandon rate averaged on a monthly basis.
(d) A toll-free busy rate not to exceed five percent (5%) of incoming calls (or the Contractors standard busy rate, if so specified) in any calendar month. The busy rate percentage shall be calculated using the hourly busy rate averaged on a monthly basis.
(e) 85 percent (85%) of incoming calls on the toll-free line will be answered by a live voice within thirty (30) seconds (or the Contractors standard live response rate and time period, if so specified) in each calendar month. Calls placed on hold within thirty (30) seconds (or the Contractors response time period) of being answered by a live voice will not be considered to meet this "live voice" performance standard. A caller must have the option to go to voicemail after three (3) minutes or continue to hold and have the call go directly to voicemail at five (5) minutes. Nothing herein shall prevent the Contractor from allowing calls to go to voicemail because of peak call times and absentees.

A.7.4 The Contractor, upon request by the State, shall review and comment on proposed revisions to the PPO option benefits. When so requested, the Contractor shall comment in regard to:

- Industry practices; and
- The overall cost impact to the program; and
- Any cost impact to the Contractor's fee; and
- Impact upon utilization management performance standards; and
- Necessary changes in the Contractor's reporting requirements; and
- System changes.

A.7.5 The Contractor shall maintain a formal grievance procedure, by which participants and providers may appeal: decisions regarding benefits administration; medical necessity determinations; and disputes arising from the utilization management program. At contract implementation, the Contractor shall provide to the State two (2) written copies describing in detail the Contractor's grievance procedures. The State reserves the authority to review the procedure and make recommendations, where appropriate. The State sponsors an appeal process available to plan members of AccessTN PPO plan

option. The Contractor's appeal process shall meet the standards set out in Section 56-32-210 Tennessee Code Annotated.

A.7.6 The Contractor shall have the appropriate qualified professionals available to participate in the State appeal process and to be available to personally attend the State appeals meetings when requested by the State. The State appeals process is available to plan members after the Contractor's appeal process has been exhausted. The Contractor shall have a qualified individual available to provide support to the State Appeals Coordinator in the research and development of appeals.

A.7.7 The Contractor shall respond to all inquiries in writing from the State within one (1) week after receipt of said inquiry. In cases where additional information to answer the State's inquiry is required, the Contractor shall notify the State immediately as to when the response can be furnished to the State.

A.7.8 The Contractor shall designate an individual with overall responsibility for administration of this contract. This person shall be at the Contractor's executive level and shall designate the following positions to interface directly with the State: (1) Program Director (external and marketing operations); and (2) Program Director (internal and administrative functions). Said designees shall be responsible for the coordination and operation for all aspects of the contract.

A.7.9 The Contractor, at the request of either party, shall meet with representatives of the State periodically, but no less than quarterly, to discuss any problems and/or progress on matters outlined by the State. The Contractor shall have in attendance, when requested by the State, a Program Director and representatives from its organizational units required to respond to topics indicated by the State's agenda. The Contractor shall provide information to the State concerning its efforts to develop cost containment mechanisms and improve administrative activities, as well as trends in the provision of group health care benefits. The Contractor shall also provide information to the State regarding the administration of the benefit, eligibility determination and enrollment, internal procedures for billing and reconciliation of transactions and the provision of health care treatment and other administrative matters.

A.7.10 The Contractor shall assist the State, if requested, in the education and dissemination of information regarding the PPO Plan options. This assistance may include but not be limited to:

- written information;
- audio/video presentations;
- attendance at meetings, workshops, and conferences; and
- training of State and the staff of the Division of Insurance Administration on Contractor's administrative and benefits procedures.

A.7.11 The Contractor shall maintain AccessTN Plan-dedicated member internet pages, providing information on plan eligibility, premiums, benefits and enrollment. Information contained at this web site shall be subject to the review and approval of the Division of Insurance Administration.

A.7.12 The Contractor shall perform, following review and approval by the Division of Insurance Administration, member customer satisfaction surveys. The survey shall be conducted no more frequently than once during each calendar year at a time mutually agreed upon by the parties and shall involve a statistically valid random sample of participants. The Division of Insurance Administration reserves the authority to review and mandate changes in the survey it feels are necessary to obtain valid, reliable, unbiased results. Those changes may include, but are not limited to, changes in the research design, units of analysis or observation, study dimension, sample size, sample frame, sample method, coding, or evaluation method. Based upon the results of the survey, the parties shall jointly develop an action plan to correct problems or deficiencies identified through this activity.

A.7.13 The Contractor shall not modify Plan PPO services or benefits provided to members during the term of this contract without the consent of the State.

A.8 **AUDIT**

A.8.1 The Contractor shall allow for periodic audits to be performed by the State of Tennessee's Division of State Audit, Office of the Comptroller of the Treasury, or other qualified entity(ies) designated by the State. For the purpose of this requirement, the Contractor shall include its parent organization, affiliates, subsidiaries, and subcontractors. The selected auditor shall be qualified to conduct such audits and shall not present any conflict of interest with the Contractor that would compromise any Contractor proprietary information. The Contractor shall provide the auditor access to all information necessary to perform the examination, and the State will work with the Contractor in defining the scope of the audit, requirements and time frame for conducting the audit. The State shall provide reasonable notice to Contractor of not less than 30 days. Contractor agrees to be fully prepared for any on-site audit on the mutually agreed upon date. To the extent allowed by applicable law, the State agrees that persons or organizations conducting audits of the Contractor shall be prohibited from disclosing confidential patient records or proprietary or confidential information reasonably designated as such by the Contractor.

For the purpose of conducting these audits, the Contractor agrees to the following:

Audits may be conducted by the State to ensure that all rebates, discounts, special pricing considerations and financial incentives have accrued to the State and PPO plan participants and that all costs incurred are in accordance with the contract terms and PPO benefits. In addition, risk sharing arrangements, performance guarantees and administrative processes as specified in this contract may be audited by the State or its qualified representative(s).

A.8.1.1 Audits may commence at any time within the three (3) year period following the period being audited.

A.8.1.2 State shall not be required to pay for any Contractor data, reporting, time, expenses or other related costs incurred by Contractor for the preparation of, or participation in, such audits.

A.8.1.3 The Contractor shall not restrict the State audit sample size or sample selection methodology. The State retains the authority to select a random sampling process, whereby a statistically valid sample of transactions completed during the audit period are analyzed, or an electronic audit process, whereby one hundred percent of transactions completed during the audit period are analyzed. In the event that the random sampling process is selected, audit results/error rates may be extrapolated for purposes of financial penalties and/or recoveries in accordance with generally accepted auditing principles. For any audit performed for purposes other than performance guarantee validation, State retains the right to choose the sampling method.

A.8.1.4 Such audits are permissible and required pursuant to the Sarbanes-Oxley Act of 2002; the American Institute of Certified Public Accounts standards; the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and the fiduciary obligations of the State. Accordingly, the Contractor shall not restrict State access to Protected Health Information (PHI) as that term is defined in HIPAA, provided the appropriate Business Associate Agreement and confidentiality agreements are in place and all applicable federal and State laws are followed.

A.8.1.5 If requested, the Contractor agrees to provide all of the following in anticipation of any audit:

a. Requested claim and/or eligibility data must be provided in Microsoft Access format and include a complete data dictionary/manual defining the codes or other nomenclature used therein. Prescription drug claims data must be provided in NCPDP format version 2.0 or higher.
b. An Operations Questionnaire completed and returned at least two weeks before commencement of any on-site audit. The Contractor shall not unduly restrict the size or scope of such questionnaire. A current SAS-70 report may be provided to supplement the questionnaire.
c. Provide complete on-line computer system access to eligibility information which will allow the auditors to verify eligibility, and effective and termination dates.
d. Complete on-line computer access to auditing/inquiry mode of the automated system and full-time use of a computer terminal for each auditor that will allow for complete re-adjudication of any claim.

e. Access to network provider fee schedules, pricing modules, rebundling software, reasonable and customary schedules, case management, utilization review notes, contracts and any internal policies or procedures as they relate to the payment structure and managed care administration provisions of the State's benefit plans.

f. Assistance/instruction in utilizing the on-line computer system and with questions regarding system coding/functions, and claim handling procedures. This includes at least one claims administrator representative to remain with the Auditors for the first full day of the on-site audit. This individual should be knowledgeable regarding system use and the audited benefit plan, and responsible for providing written responses to claims questions/potential errors. Thereafter, a representative of the claim administration staff must provide accurate and complete written responses to questions and/or potential errors identified for the audited claims within one working day.

g. Access to detailed plan descriptions and internal administrative guidelines, manuals, etc., relating to both State and general administrative claim procedures. If applicable, for Prescription Drugs / Rebates: Access to a minimum of five manufacturer contracts designated by the State. These will be based on cost and utilization.

A.9 MEDICAL AND CARE MANAGEMENT SERVICES

A.9.1 The Contractor shall provide a medical and care management system designed to help individual plan members secure the most appropriate level of care consistent with their health status. In carrying out this function, the Contractor must provide a system for reviewing the appropriateness of hospital inpatient care, skilled nursing, inpatient rehabilitative care and other levels of care as necessary. The Contractor must have in place an effective process that identifies and manages those members in need of inpatient care. The following services must be provided:

- Identification of patients in need of inpatient care for the purpose of reviewing the level of care requested and determining extent of care required, and the identification of appropriate additional or alternative services as needed. Process must include admission review, or the pre-certification/ authorization of inpatient stay.
- Concurrent review during the course of a patient's hospital inpatient stay, where qualified medical management personnel coordinate care with the hospital staff and patients' physicians. Process will review the continued hospitalization of patients and identify medical necessity for stays, as well as available alternatives.
- Discharge planning, providing a process by which medical management staff work with the hospital, patients' physicians, family, and appropriate community resources to coordinate discharge and post-discharge needs of the patient. Prevention of readmission is also a goal of the discharge planning process.
- Review of urgent and/or emergency admissions, on a retroactive basis when necessary, in order to determine medical necessity for the service.

The Contractor shall provide a written report to the State on a semiannual basis regarding the utilization of services and the demonstrated effectiveness of the programs.

A.9.2 The aforementioned services should be included as required and appropriate for hospital admissions. Pre-admission certification should not be employed for admissions for the normal delivery of children. Prospective review procedures may also include criteria for pre-admission testing and for same-day surgery procedures. If inpatient hospital pre-admission certification is utilized, authorization or denial must occur within one business day for urgent requests upon receipt by the Contractor of all necessary information regarding the admission. Any appeals of requests for continued hospitalization denials must be promptly processed and involve physician-to-physician consultation.

A.9.3 The Contractor shall maintain a case management/care management program for Plan members, utilizing procedures and criteria to prospectively and retrospectively identify members that would benefit from case management/care management services. The process of care management shall be capable of identifying the level of a patient's health status through stratification of risk in order for patients to receive the proper level of management appropriate to their condition. Care coordination/care management should consist of a full continuum of services designed to meet the level of need of the

plan member (wellness information through catastrophic case management). Contractor shall provide a written report to the State on a semiannual basis regarding the utilization of case management and care management services by the target population. Annually, the Contractor shall provide a written report that demonstrates the effectiveness of these programs as determined through valid and reliable measures of cost, quality and outcomes. The Contractor shall utilize a system of Evidence Based Medicine in the development and use of clinical practice guidelines, protocols or pathways incorporating national criteria and local physician input as appropriate. The Contractor shall also develop specialty care and outpatient case management/care management protocols when appropriate.

A.9.3.1 The Contractor shall, upon cancellation or termination of the contract for any reason, submit to the State a roster of Plan members who are, at the date termination is effective, receiving Care or Case Management services, together with all the identifying information and conditions that make the members' care appropriate for case management.

A.9.4 The Contractor shall submit to the State, at contract implementation, two (2) written copies describing its medical management/case management/care management procedures and evaluation methodology. Additionally, the Contractor shall notify the State, in writing, within thirty (30) days of any significant changes to these programs during the course of the contract.

A.9.5 The Contractor shall maintain an internal quality assurance program. The Contractor shall submit to the State, at contract implementation, a summary of the plan indicating areas addressed and methodology employed.

A.9.6 The Contractor's PPO Plan must be accredited by either the National Committee for Quality Assurance (NCQA) or the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or Utilization Review Accreditation Commission (URAC). If such accreditation is through NCQA, the Contractor shall annually submit to the State its HEDIS (Health Plan Employer Data and Information Set) report card.

A.9.7 The Contractor, in consultation with the State, shall have in place on the contract effective date disease management programs, acceptable to the State, for the following chronic conditions: congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, diabetes and asthma. The Contractor shall provide these disease management programs for those high cost, high prevalence diseases in the State-sponsored population, designed to optimize the health status of members therefore reducing the need for high cost medical intervention. The State reserves the right to review and comment on these programs. At a minimum, each disease management program shall contain the following program components:

- A Population identification process;
- Evidence-based practice guidelines;
- Collaborative practice models to include physician and support service providers;
- Patient self-management education (may include primary prevention, behavior modification programs, compliance/surveillance);
- Process and outcomes measurement, evaluation, and management; and
- Routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling).

A.9.7.1 The Contractor shall provide for each disease management program an evaluation methodology that is statistically valid and designed to measure program impact on health status, utilization of medical and pharmacy services and impact on the cost of care for the PPO plan members identified with the chronic condition. The evaluation methodology must be reviewed and approved by the State and it's benefits consultant.

A.9.7.2 The Contractor shall provide a written report to the State, no less than semiannually, detailing plan member participation in each disease management program, and in addition, a written report to the State, no less than annually, with the results of the program evaluation referenced in A.9.7.1.

A.9.7.3 The State reserves the authority during the term of the Contract to add, based on mutually agreeable terms and conditions, additional disease management or other care management

programs that have demonstrated the ability to improve the health status of plan members and effectiveness and quality of care delivered.

A.9.7.4 To assure continuity of care, the Contractor shall, upon cancellation or termination of the contract for any reason, submit to the State a roster of Plan members who are, at the date termination is effective, receiving disease management services, together with all the identifying information and conditions that make the members' enrollment in the specified disease management program appropriate.

A.10 PHARMACY

The Contractor shall provide the following required programs and service components for the retail and mail order pharmacy benefits.

A.10.1 Administrative and Account Management Support – the Contractor shall:

- Provide qualified licensed pharmacy personnel and actuarial input to assist the State in the analysis of the pharmacy program, its benefits, and policy and plan design changes.
- Collaborate with the State in proactively identifying opportunities to improve the quality of service, cost effectiveness and operational efficiency of the pharmacy benefits.
- Provide quarterly reviews of pharmacy network adequacy, Plan performance, service levels and other factors that focus on managing pharmacy benefit cost.

A.10.2 Retail and Mail Order Claims Adjudication – the Contractor shall:

- Adjudicate and process all electronic point of sale and paper retail and mail order pharmacy claims incurred during the term of the contract in strict accordance with the State's Pharmacy Benefits.
- Maintain an integrated retail and mail order electronic point-of-sale claims system that shall have edits to verify eligibility, covered drug benefits, and claim accuracy. Mail order facilities shall have the capacity to process the volume of member prescriptions.
- Make efforts to recover overpayments and reimburse underpayments to the State in accordance with applicable law and any applicable State polices regarding the collection of overpayment and reimbursement of underpayment.
- Have the ability to refill mail order prescriptions online through the website, by telephone, or by mail, subject to compliance with all applicable federal and State laws and regulations.

A.10.3 Mail Order Customer Service – the Contractor shall:

- Provide a toll-free telephone number dedicated to the pharmacy mail-order program.
- Provide special telephone services for member consultations with a registered pharmacist.
- Provide a pharmacy claims appeal process consistent with the State appeals process.
- Provide a web site for plan members providing access to pharmacy plan benefits, retail pharmacy network, Preferred Drug List (PDL), drugs requiring Prior Authorization, drugs dispensed with limitations, link to mail-order, and, if available, a secure site for members to access their pharmacy claims.

A.10.4 Retail Network – the Contractor shall:

- Provide a comprehensive network with member access to retail pharmacies, which contractually agree through point-of-sale electronic transmission to verify eligibility, submit member claims electronically, agree not to waive co-payments or deductibles, and agree to accept the Contractor's reimbursement as payment in full for covered prescription drugs allowing no balance billing.
- Provide participating pharmacies with a toll-free telephone service number.
- Maintain a pharmacy audit program in order to ensure pharmacy compliance with the program.
- Require its network retail pharmacies, who have agreed with the contractor's terms and conditions for mail order pharmacy to provide three month drug supplies via US Postal service, upon request by members, as required by the State's mail order pharmacy policy.

A.10.5 Formulary/Preferred Drug List (PDL) and Utilization Review – the Contractor shall:

- Implement and maintain a Formulary/ PDL for the retail and mail order program that is designed to maximize the prescribing and dispensing of safe and clinically and cost effective drugs within each therapeutic class. Changes in the PDL shall be approved and communicated to the State and affected plan members no less than 30 days prior to change implementation date, unless, a shorter notification time is mutually agreed to by the Contractor and State.
- Provide a Prospective Utilization Review program for the retail and mail order programs allowing pharmacists access to patient prescription drug profile and history in order to identify potentially adverse events, including but not limited to the following:
  - Drug to drug interaction
  - Duplicate therapy
  - Known drug sensitivity
  - Over utilization
  - Maximum daily dosage
  - Early refill indicators
  - Suspected fraud
- Provide for clinical pharmacist follow-up to dispensers and prescribers in order to share relevant information from the drug utilization review analysis.
- Provide a Retrospective Utilization Review program to track provider prescribing habits and identify those who practice outside of their peer norms as well as identify patients who may be abusing prescription drugs or visiting multiple providers.
- Provide a specialty pharmacy program to address the introduction of new biological drugs and drugs to treat plan members with conditions such as hepatitis C, multiple sclerosis, arthritis and hemophilia. Such a program should provide for significant discounts off the Average Wholesale Price (AWP), delivery to the member, and pharmacist and nursing support.
- Have the ability to lock a member suspected of abusing the system into just one network pharmacy.

A.10.6 Therapeutic Substitution and Generic Dispensing Program – the Contractor shall:

- Provide a Therapeutic Substitution program with provisions for appropriate contact to prescribing physician in order to advise them of the potential savings resulting from substituting a costlier drug with a lower cost medically appropriate alternative drug. Results of the program should be reported to the State on an annual basis.
- Provide a Generic Dispensing program designed to maximize the acceptance and use of medically appropriate generic drugs under the retail and mail service program. The program shall target physicians, pharmacists and plan members. Results of the program should be reported to the State on annual basis.
- Maintain a communication plan by which notification will be made to affected members when the most frequently utilized brand name medications lose their patent classification and become available as a generic equivalent.

A.10.7 Pharmacy Rebates and Audits – the Contractor shall:

- Remit to the State no less than quarterly a check for all pharmacy rebates obtained on behalf of the State due to the use of pharmaceuticals by members of the State-sponsored Plans for the rebates accrued during the claim period ending 6 months prior to the rebate payment date.
- With provision by the State of 30 days notice, and with execution of any applicable third party confidentiality agreements, submit to examination and audit of applicable pharmacy benefit data by the State, including manufacturer rebate contracts and rebate payments, by the State's authorized independent auditor (experienced in conducting pharmacy rebate audits) during the term of this contract and for three years after final contract payment (longer if required by law). For the purpose of this requirement, Contractor shall include its parents, affiliates, subsidiaries and subcontractors. Such audits shall include third party confidentiality agreements between the auditor and the party being audited.
- With provision by the State of 30 day notice, and with the execution of any applicable third party confidentiality agreements, provide full disclosure of rebates received by the Contractor, its affiliates, subsidiaries, or subcontractors on behalf of the State, including line item detail by National Drug Code number and line item detail by pharmaceutical manufacturer showing actual cost

remitted and other related claim and financial information as needed to satisfy the scope of the audit. The Contractor will, upon request by the State, disclose to the State's authorized independent auditor (experienced in conducting pharmacy rebate audits) any administrative fees or other reimbursements received in connection with any rebates, discounts, fee reductions, incentive programs, or the like received by Contractor as a result of the drug manufacturer payments which include volume of pharmaceutical use by or on behalf of the State. In addition, Contractor will, upon request by the State, disclose fees or other reimbursements received in connection with any grants, educational programs or other incentive programs received by the Contractor on behalf of the State.

- With the execution of any applicable third party confidentiality agreements, provide at any time, upon 30 day notice from the State, access to audit the pharmacy rebate program, including but not limited to rebate contracts, special discounts, fee reductions, incentive programs or the like with pharmacy manufactures and program financial records as necessary to perform accurate and complete audit of rebates received by the State. At the State's discretion, the State's authorized independent auditor (experienced in conducting rebate audits) may perform such audit. The State is responsible for the cost of it's authorized third party representative for such audits. If the outcome of the audit results in an amount due to the State, payment of such settlement will be made within 30 days of the Contractor's receipt of the final audit report.

A.10.8 Pharmacy Benefit Carve Out: The State reserves the authority to "carve out" the pharmacy benefit during the term of the contract upon a 120-day notice to the Contractor. If the State notifies the Contractor of its intention to exercise this option, the Contractor shall remain responsible for the payment of incurred pharmacy claims up to the effective date of the carve out of the pharmacy benefit.

A.11 DATA AND SPECIFIC REPORTING REQUIREMENTS

The Contractor shall:

A.11.1 Maintain a duplicate set of all records relating to the benefit payments in electronic medium, usable by the State and Contractor for the purpose of disaster recovery. Such duplicate records are to be stored at a secure fire, flood, and theft- protected facility located away from the storage location of the originals. The duplicate data processing records shall be updated, at a minimum, on a daily basis and retained for a period of 60 days from the date of creation. Upon notice of termination or cancellation of this contract, the original and the duplicate data processing records medium, and the information they contain shall be conveyed to the State on or before the effective date of termination or cancellation.

A.11.2 Reconcile, within ten (10) working days of receipt, payment information provided by the State. Upon identification of any discrepancies, the Contractor shall immediately advise the State.

A.11.3 Annually provide the State with a GeoNetworks® report showing service and geographic access. The State shall review the network structure and shall inform the Contractor in writing of any deficiencies the State considers to deny reasonable access to health care. The State and Contractor shall then mutually develop a plan of action to correct said deficiencies within sixty (60) days.

A.11.4 The Contractor is required to transmit **plan enrollment data monthly** and medical and prescription drug claims **quarterly** to the Division of Insurance Administration's healthcare decision support system (DSS) vendor (currently Medstat) until all claims incurred during the term of this contract have been paid. Data shall be submitted in the format detailed in **Attachment E.** The Contractor shall ensure that all claims processed for payment have valid provider identifications and complete ICD-9 and CPT4 codes (and when applicable, updated versions).

For each quarter of the contract term, and any extensions thereof, claims data must meet the quality standards detailed in **Contract Attachment A, Performance Guarantees #7**, as determined by the State's healthcare claims data management vendor (currently Medstat).

The Contractor will work with the State's DSS vendor to identify a data format similar to the format detailed in **Attachment E** for these transmissions, and is responsible for the cost incurred by the DSS vendor to develop, test and implement conversion programs for the Contractor's claims data. The

State's DSS vendor currently charges a maximum of $30,000 per new contractor. Furthermore, the Contractor will pay during the full term of this contract all applicable fees as assessed by the State's DSS vendor related to any data formats changes, which are Contractor-initiated or are due to meeting compliance with new regulations. The Contractor will also pay all applicable fees related to any DSS vendor efforts to correct Contractor data quality errors that occur during the term of this contract.

Claims data are to be submitted to the State's health and decision support system vendor no later than the last day of the month following the end of each calendar quarter **(see Contract Attachment A, Performance Guarantees #9)**.

A.11.5 Submit Management Reports as required by the State in electronic format (MSWord, MSExcel, etc.) and hard copy format, of the type, at the frequency, and containing the detail described in **Contract Attachment B Management Reporting Requirements**, shall continue for the twelve (12) month period following termination of the contract.

A.11.6 The Contractor shall participate and cooperate with the State to implement a secure, web-accessible community health record (CHR) for AccessTN members. Cooperation shall include, but may not be limited to, the provision of encounter/results data directly to an authorized CHR vendor in a time and manner approved by the State and consistent with the requirement of the CHR vendor and an executed Business Associates Agreement between the Contract and the CHR vendor. The Contractor shall require subcontractors and providers to participate and cooperate with the State and/or a CHR vendor.

A.12 SERVICES PROVIDED BY THE STATE

A.12.1 The State shall fund applicable accounts from which the Contractor will make claims payments during the term of the contract, and for the thirteen (13) months following its termination, for care and treatment services delivered within the term of the contract (reference Contract Section A.5.13).

B CONTRACT TERM

B.1 This Contract shall be effective for the period commencing on February 13, 2007 and ending on December 31, 2009. The State shall have no obligation for services rendered by the Contractor which are not performed within the specified period.

B.2 Term Extension. The State reserves the right to extend this Contract for an additional period or periods of time representing increments of no more than one year and a total contract term of no more than five (5) years, provided that the State notifies the Contractor in writing of its intention to do so at least Two Hundred Seventy (270) days prior to the Contract expiration date. An extension of the term of this Contract will be effected through an amendment to the Contract. If the extension of the Contract necessitates additional funding beyond that which was included in the original Contract, the increase in the State's maximum liability will also be effected through an amendment to the Contract, and shall be based upon rates provided for in the original contract.

C PAYMENT TERMS AND CONDITIONS

C.1 Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Four Million Six Hundred Thousand Dollars ($4,600,000.00). The Service Rates in Section C.3 shall constitute the entire compensation due the Contractor for the Service and all of the Contractor's obligations hereunder regardless of the difficulty, materials or equipment required. The Service Rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor.

The Contractor is not entitled to be paid the maximum liability for any period under the Contract or any extensions of the Contract for work not requested by the State. The maximum liability represents available funds for payment to the Contractor and does not guarantee payment of any such funds to the Contractor under this Contract unless the State requests work and the Contractor performs said work. In which case, the Contractor shall be paid in accordance with the Service Rates detailed in Section

C.3. The State is under no obligation to request work from the Contractor in any specific dollar amounts or to request any work at all from the Contractor during any period of this Contract.

C.2 Compensation Firm. The Per Member Per Month (PMPM) Rates and the Maximum Liability of the State under this Contract are firm for the duration of the Contract and are not subject to escalation for any reason unless amended.

C.3. Payment Methodology. The Contractor shall be compensated based on the rates herein for service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in Section C.1. The Contractor's compensation shall be contingent upon the satisfactory completion of units of service or project milestones defined in Section A. The Contractor shall be compensated based upon the following PMPM Rates:

PMPM Administrative Fee	PMPM 2007	PMPM 2008	PMPM 2009
AccessTN Plan	$18.57	$18.57	$18.57

If the State, subject to a sixty (60) day notice, elects to provide for the administration of the Pharmacy Benefit (as detailed in A.10) or Disease Management (as detailed in A.9.7) or to collect premiums (as detailed in A.3) then the PMPM administrative fee shall be reduced by the associated amount detailed in the schedule below. If the adjustment takes place in the first or second year of the contract extension provided for in B.2., then the carve out reduction amounts will be increased by the same percentage that resulted from the process outlined below in C.3.1 or C.3.2.

Potential Carve Out	PMPM 2007	PMPM 2008	PMPM 2009
Reduction for Disease Management	$1.09	$1.09	$1.09
Reduction for Pharmacy	$0.78	$0.78	$0.78
Reduction for Premium Collection	$1.24	$1.24	$1.24

The Contractor shall submit monthly invoices, in form and substance acceptable to the State with all of the necessary supporting documentation, prior to any payment. Such invoices shall be submitted for completed units of service for the amount stipulated. The State shall compensate the Contractor monthly for all services outlined in this contract, at the PMPM rates indicated, based upon the number of members certified by the State to the Contractor.

C.3.1 If this Contract is extended pursuant to Section B.2., the following shall apply. For services performed from January 1, 2010, through December 31, 2010, the Contractor shall be compensated based upon the Service Rates fixed in Section C.3, above but the rates shall be adjusted by the percentage increase, if any, between the Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, All Items expenditure category, not seasonally adjusted, index base period: 1982-84=100) published by the United States Department of Labor, Bureau of Labor Statistics (or its successor index) in December 2009 and that figure published in the same month, 12-months prior, up to a maximum of three and one-half percent (3.5 %).

C.3.2 If this Contract is extended a second time pursuant to Section B.2., the following shall apply. For services performed from January 1, 2011, through December 31, 2011, the Contractor shall be compensated based upon the Service Rates fixed in Section C.3, above but the rates shall be adjusted by the percentage increase, if any, between the Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, All Items expenditure category, not seasonally adjusted, index base period: 1982-84=100) published by the United States Department of Labor, Bureau of Labor Statistics (or its successor index) in December 2010 and that figure published in the same month, 12-months prior, up to a maximum of three and one-half percent (3.5 %).

C.3.3 The State authorizes the Contractor to retain administrative fees, on a per patient basis, of no more than 5% of the gross recoveries received. The Contractor may retain an additional 20% of the gross recoveries, when such recoveries are made by subrogation subcontractor(s). The Contractor shall understand that recovery of subrogation claims includes claims paid as a result of work related illnesses or injuries relative to worker's compensation claims.

C.3.4 The State agrees that access fees required by the Contractor, and its licensees, for use of the BlueCard program by members covered under the Plan shall be deducted from the aggregate discount savings realized from the Blue Card Program with the savings balance accruing to the State. The maximum fees under the Blue Card program are as follows:

Type of Claim	**State's cost per Claim**
Professional Claim	$4.00
Institutional Claim	$9.75
Claim Based Access Fee Only if Charged by Host Plan	4.3% of the discount received from the Host Plan if required. Maximum of $2,000 per claim.

All other fees related to the Blue Card Program, as described in Contract Attachment G Blue Card PPO Program shall be borne by the Contractor, and should not be charged separately to the State regardless of any contrary statement in Attachment G. The State is under no obligation for any fees or compensation under the Blue Card Program other than those contained in this section.

Contractor shall provide the State with quarterly reports on the utilization of the Blue Card Program including claims paid, realized savings and Blue Card Program fees paid out of savings for the program during the quarter. Reports should be provided by the last day of the month following the quarter.

C.4 Performance Guarantees. The Contractor agrees to be bound by the provisions contained in Contract Attachment A, Performance Guarantees, and to pay amounts due upon notification of Contractor non-compliance by the State.

C.4.1 Performance Guarantees under Contract Extension. If this Contract is extended, per Section B.2, the Performance Guarantees shall remain unchanged for the years extended.

C.5 Travel Compensation. The Contractor shall not be compensated or reimbursed for travel, meals, or lodging.

C.6 Payment of Invoice. The payment of the invoice by the State shall not prejudice the State's right to object to or question any invoice or matter in relation thereto. Such payment by the State shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any of the amounts invoiced therein.

C.7 Invoice Reductions. The Contractor's invoice shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the State, on the basis of audits conducted in accordance with the terms of this contract, not to constitute proper remuneration for compensable services.

C.8 Deductions. The State reserves the right to deduct from amounts which are or shall become due and payable to the Contractor under this or any contract between the Contractor and the State of Tennessee any amounts which are or shall become due and payable to the State of Tennessee by the Contractor.

C.9 Automatic Deposits. The Contractor shall complete and sign an "Authorization Agreement for Automatic Deposit (ACH Credits) Form." This form shall be provided to the Contractor by the State. Once this form has been completed and submitted to the State by the Contractor all payments to the Contractor, under this or any other contract the Contractor has with the State of Tennessee shall be made by Automated

Clearing House (ACH). The Contractor shall not invoice the State for services until the Contractor has completed this form and submitted it to the State.

D STANDARD TERMS AND CONDITIONS

D.1 Required Approvals. The State is not bound by this Contract until it is approved by the appropriate State officials in accordance with applicable Tennessee State laws and regulations.

D.2 Modification and Amendment: This Contract may be modified only by a written amendment executed by all parties hereto and approved by the appropriate Tennessee State officials in accordance with applicable Tennessee State laws and regulations.

D.3 Termination for Convenience. The Contract may be terminated by either party by giving written notice to the other, provided that the State shall give said notice to the Contractor at least Ninety (90) days before the effective date of termination, and the Contractor shall give said notice to the State at least Two Hundred and Seventy (270) days before the effective date of termination. Should the State exercise this provision, the Contractor shall be entitled to compensation for all satisfactory and authorized services completed as of the termination date. Should the Contractor exercise this provision, the State shall have no liability to the Contractor except for those units of service which can be effectively used by the State. The final decision as to what these units of service are, shall be determined by the State. In the event of disagreement, the Contractor may file a claim with the Tennessee Claims Commission in order to seek redress.

D.4 Termination for Cause. If the Contractor fails to properly perform its obligations under this Contract in a timely or proper manner, or if the Contractor violates any terms of this Contract, the State shall have the right to immediately terminate the Contract and withhold payments in excess of fair compensation for completed services. Notwithstanding the above, the Contractor shall not be relieved of liability to the State for damages sustained by virtue of any breach of this Contract by the Contractor.

D.5 Subcontracting. The Contractor shall not assign this Contract or enter into a subcontract for any of the services performed under this Contract without obtaining the prior written approval of the State. If such subcontracts are approved by the State, they shall contain, at a minimum, sections of this Contract pertaining to "Conflicts of Interest" and "Nondiscrimination" (sections D.6. and D.7.). Notwithstanding any use of approved subcontractors, the Contractor shall be the prime contractor and shall be responsible for all work performed.

D.6 Conflicts of Interest. The Contractor warrants that no part of the total Contract Amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Contractor in connection with any work contemplated or performed relative to this Contract.

D.7 Nondiscrimination. The Contractor hereby agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the Contractor on the grounds of disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law. The Contractor shall, upon request, show proof of such nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

D.8 Prohibition of Illegal Immigrants. The requirements of Public Acts of 2006, Chapter Number 878, of the state of Tennessee, addressing the use of illegal immigrants in the performance of any contract to supply goods or services to the state of Tennessee, shall be a material provision of this Contract, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Contract.

a. The Contractor hereby attests, certifies, warrants, and assures that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an